Putting Suffering Into Perspective

Implications of the Patient's World View

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The need for suffering patients to reexamine their assumptions about life presents therapists with unique challenges and opportunities. Patients with a religious world view often struggle with whether God cares about, or has sent, their pain. Atheistic patients also search for the meaning in their lives but reject the answers offered by traditional authorities. Patients who are uncertain or ambivalent about their world view may challenge a therapist to provide an audience, insight, or direction. Using case examples, the author explores the therapist's role in helping patients with differing world views to integrate their suffering.

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The meaning of pain defines suffering. An athlete may expect and even embrace pain during a game but may suffer if his injury disables him or causes his team to lose. A person who is injured intentionally and ignored is likely to suffer more than one who is hurt accidentally and treated with care.

Suffering is a central concern of psychotherapy. In addition to helping patients acknowledge and bear pain, therapists use a variety of approaches to help them put pain into perspective.[1] For example, a therapist may explore whether the expectations of a patient disappointed by a friend are realistic, and if not, what reasons she may have for holding onto those expectations. Together they may uncover the patient's maladaptive schemas for interpreting reality[2] or use cognitive strategies to correct for distorting tendencies such as a tendency to see life through the dark glasses of depression.[3] Therapists also recruit placebo or transference effects to shape the meaning to patients of their healing interventions.[3–5]

The task of putting profound suffering into perspective can require grappling with larger questions. For example, serious physical illness often prompts individuals to reassess what gives their lives significance.[6–8] Survivors of childhood sexual abuse may need to rebuild their shattered assumptive worlds so as to achieve a new take on themselves, on their hopes, and

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on reality.[9] In this article I consider the ways that therapists can help patients with different world views to integrate suffering.

In his 1933 paper "The Question of a Weltanshauung,"[10] Freud identified the possession of a world view as one of the ideal wishes of human beings. He defined a Weltanschauung as "an intellectual construction which solves all the problems of our existence uniformly on the basis of one overriding hypothesis," and he described two basic categories of world view: the religious or theistic, and the naturalistic or materialistic (which he termed the "scientific"). Although his friends and long-time correspondents Oscar Pfister[11] and Romain Rolland[12] tried to persuade him that religious and mystical experiences could not be understood in only scientific terms, Freud maintained his position that a scientific outlook and a religious world view were mutually incompatible. Without following Freud here, or wishing to oversimplify the varieties of religious (and spiritual) experience, I borrow for its clinical usefulness his distinction between religious/theistic and naturalistic/atheistic world views, and I consider in addition people whose understanding of ultimate reality is uncertain or ambivalent.

Freud's sharp critique of what he saw as the pathological origins of the religious world view deterred many of his followers from considering the clinical implications of a person's world view. However, in recent years mental health professionals have increasingly recognized the clinical relevance of spirituality, which is usually defined more broadly than religion as a connection to a larger or transcendent reality.[12,13] They have also described cultural, ethical, transference, and countertransference aspects of treating religious patients.[14–17] However, relatively little attention has been directed to the implications of different belief systems embraced by patients for accomplishing basic psychotherapeutic tasks such as integrating suffering.

THE RELATIONSHIP BETWEEN SUFFERING AND WORLD VIEW

A person's world view helps to shape the meaning of her painful experience.[18] An individual who trusts in God as a protector of good people may feel cheated, if not punished, by a diagnosis of cancer. A believer with a different understanding of God may wonder if the same illness is intended to discipline him or bring him closer. Cancer may remind a Buddhist of the need to transcend desire and attachment, an atheist of his most important accomplishments or values.

Conversely, suffering can also influence one's world view. Freud[19] taught that the child's wish for comfort in the face of life's cruelties gave rise to the later adult's adherence to a religious world view. However, more recent work by Ana-Maria Rizzuto and others suggests that the process by which belief and unbelief develop is more complicated. Rizzuto's observations[20] suggest that every person has a god concept or object, and that an individual's relationship to that object (whether marked by belief, fear, hatred, or unbelief) is conditioned by both pleasurable and painful experiences with important others. Vetter and Green's study of atheists[21] is consistent with this view. In a survey of 350 members of the American Association for the Advancement of Atheism, they found that half of the younger atheists had lost one or both parents before the age of 20. A large number of this group also described themselves as unhappy in childhood and adolescence. As Pargament[18] has suggested, "it may be that although the majority of individuals turn to religious explanations at the boundary conditions of life, a smaller number find belief in a personal, loving God impossible to square with events such as the death of a parent at so young an age" (p. 161).

THE THERAPIST'S ROLE

In treating a patient who is struggling with the larger meaning of pain or loss, therapists do well to identify the resources for dealing with suffering that are contained in his particular world view. Jews can find in the Psalms and in the story of Job precedent for the sufferer to call out to and question God. Christians can also see in Christ's suffering evidence that God cares about their suffering because he has taken it on himself—thus dignifying suffering on behalf of others. Buddhists find in the dharma support for detaching from the desire that leads to suffering. Atheists faced with suffering may instead take pride in their own integrity, intellectual honesty, or stoicism. A therapist may also need to help a patient address the particular challenges presented by her world view in coming to terms with suffering.

Individuals with a spiritual or theistic world view often feel that someone cares about their pain and that they are not ultimately alone. However, they may also be struggling with the concept that a God who is pow-

erful enough to have spared them illness did not choose to do so. Theological, philosophical, and popular texts that address this problem of theodicy include Rabbi Kushner's *When Bad Things Happen to Good People*[22] and C. S. Lewis's *The Problem of Pain*.[23] Rather than being expected to offer such philosophical consultations, clinicians will usually find that believing patients (like nonbelievers) instead most often want a chance to be heard and to talk about their concerns with someone who will understand the importance those concerns have for them—someone who will neither suggest his own answers to their questions nor reduce them to something more psychodynamic. They may also need to reflect on, and to think through, their own beliefs and doubts. The account by the Christian apologist C. S. Lewis of his experience of his wife's death, *A Grief Observed*,[24] is a compelling description of this process.

Clinicians are sometimes inhibited in exploring a believer's struggle by a desire to stay close to the familiar role of discussing the psychological dimension of the patient's problems, or by a wish to respect the patient's privacy. This may cause them to underestimate their potential for helping patients disentangle the intertwined contributions of psychopathology, formative traumatic experiences, and/or patients' undeveloped understanding of the teachings of their own religious tradition.

A 40-year-old married Catholic mother of three worried that her diagnosis of ovarian cancer was a punishment from God for having had an abortion. Her view of God had not changed much since her time in Sunday School, and she seemed unaware that her fear did not accord with her church's teaching. On exploration, it appeared that these fears were also related to her growing up with a strict and punitive father, as well as to her tendency to respond to stress with worry and self-blame.

Treatment included reducing her initial extreme anxiety by using medication, then considering with her over several sessions the sources of her fears and most troubling beliefs. She and her therapist explored her experiences of God and of prayer, and discussed the messages she received in Sunday school as compared with her developing adult understanding of forgiveness within her Catholic tradition. Her therapist also offered a referral to the in-hospital priest as a person who could better help her understand what her faith taught. Having achieved some perspective on the contribution of her anxiety to her beliefs, she was able to clarify and then to deepen her trust in God as she entered the terminal phase of illness.

As in this case, a patient's religious world view can appear to be adding to her suffering—for example, by inducing unreasonable guilt.[25] Consultation with a colleague who shares, or is more familiar with, the nuances of the patient's faith tradition can be very useful in distinguishing what the tradition actually holds compared with the patient's own interpretation.[26]

Working through issues such as these can often help prevent estrangement of believers from some of their more important relationships at a time when they need them most—with God, if the patient feels they are no longer on speaking terms, and from religious friends who may not be able to tolerate the patient's hard questions.

Individuals with a naturalistic or atheistic world view consciously reject a purposeful explanation for the universe. As a result, they may feel ultimately alone and anxious in bearing pain. Like many sophisticated believers, they see illness as no one's fault, except perhaps their own through mistakes they made in bringing it on or failing to detect it in its early forms. Instead, they often struggle to achieve a kind of Eriksonian integrity, or ability to live and die consistent with who they are. Some of these individuals seek out a clinician's help to review their lives, consolidate their own commitments, and find a secular perspective that will integrate these core values. Viederman and Perry[27] have described a narrative approach to this process in their paper on the treatment of depression in the medically ill. The following vignette describes such a process in therapy.

An atheistic scientist with lung cancer came for treatment because of anxiety about dying and difficulty thinking through whether or not she should request assisted suicide. Growing up in a disadvantaged neighborhood, she had been befriended by a teacher and then gone on to become extremely successful as a "self-made" leader in her field. What helped her most with her anxiety was to realize (as she had the night before learning that she had been granted tenure) that she could live without her work, and that the scientific and personal integrity that had given her life value was a legacy that she could pass on to others.

As is the case with religious patients, clinicians who are overly shy or inhibited about exploring a patient's rejection of belief may miss its relevance to their work.

A 50-year-old woman with bladder cancer came for treatment because she was anxious, depressed, and angry. To her therapist's routine question about spiritual beliefs or practices, she responded that she had none. His interest in her emphatic response led to her disclosure that she had been raised in a rigid religious commune, had felt traumatized by this, and had definitively left both her religious faith and their beliefs behind. Her attitude toward authority figures in

the commune rather directly paralleled the resentment she currently had toward both her oncologist, whom she experienced as somewhat distant and condescending, and the God she had rejected.

Just as in treating a religious patient with whom a clinician either identifies or disagrees strongly, a therapist can also become overly interested in his own relationship to an atheistic belief system, losing the focus of the alliance and potentially engaging in unproductive discussion or arguments. This patient's psychiatrist could have focused with her on the psychodynamic origins of her atheism. Instead, he acknowledged that her feelings of estrangement toward authorities were understandable given her early experiences and, as she felt more secure, asked her if she had considered reestablishing contacts with her family of origin.

Suffering makes many patients realize that they are uncertain or ambivalent about their philosophy of life. They may consider themselves as "lapsed" churchgoers or skeptics who have rejected organized religion but retained a strong sense of personal spirituality. A number of challenges face clinicians in attempting to help agnostic patients clarify their beliefs about what matters most, think through their questions, and consolidate their values so as to live in accord with their deepest commitments. One such challenge is to determine when a therapist should be the one to help the patient sort through the spiritual and emotional aspects of his struggle.

A 70-year-old Jewish artist came for help in dealing with his metastatic colon cancer. He listed several problems: his wife's distress and talk of suicide if he died; rage at feeling he was at the mercy of "a film director who keeps you in the dark about your role in life"; sadness at losing "the poignant beauty of life"; and feelings of guilt (which he saw as irrational) involving the sense that his suffering might be a deserved punishment for being a negligent father and a poor citizen to the community. As an admirer of Freud's cold honesty, he was unable to believe that death was any kind of "going to the light," but he also described himself as engaged in an intense spiritual quest, reading everything he could find about how to face it with some kind of solace and peace.

His early life had been marked by painful discrimination and by domination from a mother whom he felt he had spent his entire life unsuccessfully trying to please. His father was rough, illiterate, seldom home, and ineffective in protecting him from his mother. He brought to his consultation a past history of some psychotherapy and considerable insight into himself, but he felt he might need help to sort through what he described as "a thousand instruments playing different tunes."

It became clear that he could not easily accept the narcissistic injury that death represented, but neither could he believe that "the exquisite beauty of a butterfly's wing came about by accident." He had not been religious since his Bar Mitzvah, but his Jewishness was somehow central to his spiritual quest.

What he wanted from a professional was primarily an admiring, attentive-enough audience and reassurance that he was on the right track in sorting out the various influences throughout his life on his attitudes, his values, and his hopes for himself and his family. He was ambivalent about whether he needed ongoing psychotherapy.

In the process of a consultation, he eventually came to feel that he was already actively engaged in the work of dying—that is, of bringing together these aspects of himself and of taking into account the psychological influences without letting them determine his responses. For example, reflecting on how he had reconciled with his father, he could see the potential for reconciling the sharply conflicting parts of himself and for helping his wife find a way to go on. To put it another way, he was on his way to forging out of painful experience his own perspective, not just on his current illness, but on life, and on himself as someone who had lived through many losses before. The challenge for the therapist in consulting with this highly imaginative and articulate man was how to facilitate, support, and acknowledge the connections he was making between his suffering and his beliefs, without getting in his way by delving into either psychological or spiritual aspects of the man's struggle on his own initiative.

Assuming that a therapist has a role in sorting through the spiritual and emotional aspects of an agnostic patient's struggle, how should he as a therapist respond to a patient's requests for more direction? Should a clinician, if asked, reveal his own world view? Should he be willing to offer a range of options for exploring the questions further, for example by recommending readings or different types of churches? An extensive literature now explores the clinical, transference, countertransference, boundary, and consent considerations that arise in treating religious patients, much of which can be usefully extrapolated to treatment of more ambivalent ones.[14–17,26,28] In addition, the American Psychiatric Association has published "Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitments and Psychiatric Practice."[29] These suggest that a clinician deal with these requests for self-disclosure as with any other, taking into account what the patient needs most and what the request means in light of the transference and countertransference. In addition, clinicians can generally use their shared knowledge of a particular tradition to help patients address obstacles and point them in the direction of pastoral resources (such as a hospital chaplain) when asked.

Perhaps the most difficult challenge is presented by those agnostic patients (often character-disordered, with narcissistic traits or substance abuse) who lack both a framework of meaning and the insight that they need direction. The psychologist and philosopher Søren Kierkegaard would have diagnosed them with "the sickness unto death," or "the despair that does not know it is in despair." Assessing the readiness of such individuals to accept intervention and insight presents unique challenges for the timing and tact of the therapist.

A physician in his fifties, with a reputation for technical expertise, young lifestyle, and an arrogant attitude toward nurses, was referred for a mandated psychiatric evaluation after being charged with driving under the influence (DUI). In the process of his assessment, the psychiatrist consulted with a colleague who had seen the patient a few years before. The first psychiatrist recalled that the patient came for help with depressive symptoms following his third divorce. The divorce had seemed to reflect a pattern of treating people other than his superiors in a peremptory way, consistent with his impression that the patient was "a narcissistic character who does not understand women." He had treated him supportively for several sessions until his depression improved.

As a condition of retaining his license following his DUI charge, the patient began attending 12-step meetings, initially with considerable skepticism. He found that he admired the wisdom of many speakers who were in longer-term recovery, and he eventually became active in Alcoholics Anonymous. In therapy, he reported that the 12-step program had enabled him to see himself for the first time as "angry and self-centered" and had allowed him to begin repairing these "character defects."

Was there a realistic possibility that this patient's first psychiatrist could have shown him that his life was a mess? Could he have helped him find a direction by exploring what he cared most about and why he cared about it? It may be that the patient needed the crisis of the threatened loss of his license (and exposure to others who had more direction in AA) to begin to face the reasons for his suffering. However, examples such as his raise the question of whether a therapist who can clearly see a patient's need for direction can bring it to his attention in time to avert a crisis.

DISCUSSION

These examples illustrate the relevance of a patient's world view to the task of integrating suffering. They raise the question of whether it might be similarly fruitful to take basic beliefs into account in accomplishing other therapeutic tasks, such as clarifying the patient's hopes, life direction, or moral values.

Clearly, a good therapist would assess the needs of the patient as a whole person in the largest possible context, but there are risks involved in attempting to address needs in this way in the role of a therapist. Clinicians can influence vulnerable patients in the direction of adopting their own world views, whether religious or naturalistic. They can also become distracted from the task of doing what the patient needs most from them in their capacity as expert psychological resources.

At the same time, there are risks attached to remaining distant from patients' search for answers to ultimate questions. Therapists can trivialize patients' search by reducing it to merely a "psychological" need for meaning that reflects a more basic need for security or significance. When they do this, they are likely to miss valuable opportunities to help patients integrate a transcendental perspective of the self.

Suffering patients need to feel that their therapists not only take seriously their search for answers to ultimate questions such as the meaning of their suffering, but that they are willing to join them in this search.

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